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AUTHOR Wolfenden, Deborah Parker; Stockford, David Noble
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ABSTRACT

Medicaid is the principal source of public funding for therapeutic interventions for children birth to 21 years of age and can be used to support health-related services of special education programs. An overview discusses Medicaid provisions related to state medical assistance plans; Medicaid's status as an entitlement, which means that services are not limited by federal budgetary appropriations; eligibility; mandatory services; and optional services. Of key importance to special education is the provision of early, periodic screening, diagnosis, and treatment services to persons below the age of 21. During the 1990s, a collaboration between Maine's Department of Education and Bureau of Medical Services (the state Medicaid office) developed strategies whereby health-related services could be delivered within public schools and partially funded by Medicaid reimbursements. Eligible costs included the health-related portion of special education costs, covering various types of therapy and rehabilitation, screening services, nursing services, and medical transportation. The collaborating state agencies developed a monthly blended-payment system that reimburses school administrative units (SAUs) for eligible services covered in the individual education program. A January 2000 survey of SAUs found that almost all respondents had billed Medicaid during 1998-99; about half had used Medicaid revenues to maintain or expand special education or school health services; and further training was needed. (SV)

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Deborah Parker Wolfenden, M.Ed., CCC-SLP
Funding Research and Consulting
163 Brown Road
Durham, Maine 04222

David Noble Stockford, M.Ed.
Director
Office of Special Services
Maine Department of Education
23 State House Station
Augusta, Maine 04333-0023

COLLABORATIVE WORKING RELATIONS WITH YOUR STATE MEDICAID OFFICE: WHAT'S IN IT FOR YOU?

Overview:

The Medicaid program was established in 1965 when Title XIX was added to the Social Security Act. (42 U.S.C. Section 1396 *et seq.*; 42 C.F.R. Parts 430 to 456. Like the Individuals with Education Act (I.D.E.A.), Medicaid is an example of "cooperative federalism". In this relationship, the federal and state (or federal, state and local) government share responsibilities for providing benefits, in this case, to the poor. The federal government sets general program criteria and provides financial assistance to the states. The states, or state and local government, are responsible for the administration of the program and meeting part of the program's costs.

States must choose to participate in the Medicaid program. In order to convey their choice, the states must prepare and submit a state medical assistance plan to the Health Care Financing Administration (HCFA). This state plan must meet the criteria established by the federal government. (42 U.S.C. Section 1390a(a)). The state plan must include more than four dozen provisions. Key provisions include: the assurance that the plan will be administered on a statewide basis and that a single state agency will be responsible for administration of the program. The state plan must also provide assurances regarding the state's financial contribution to the program, and identify the mandatory and optional services, which will be a part of the Medicaid program.

Despite the large number of federal program criteria, the states have extraordinary control over the operations of the Medicaid program. Examples include whether to participate at all; what services beyond the mandatory minimum to cover; which groups of persons to include; enrollment of and reimbursement rates for providers; all eligibility and coverage decisions; and the administrative process for reviews of eligibility and/or coverage denials. In addition, there are minimal requirements imposed on the states when they seek to change their state plans, whether to increase or decrease coverage.

The Medicaid Act can and should be viewed as a principal source of public funding for therapeutic interventions for children birth to 21 years of age. Medicaid is one of the largest programs in the federal budget and most assuredly one of the largest components of every state budget. Importantly for Medicaid-eligible recipients is the fact that Medicaid is an entitlement. Simply put, Medicaid services must be provided without limits set by budgetary appropriations. Eligible persons may access covered services and providers may provide covered services without fear that reimbursement will be denied by one of Medicaid's funding partners. Services cannot be denied due to exhaustion of appropriated resources. Unlike most programs, Medicaid's appropriation does not represent expressed limits on spending. The appropriated amounts merely represent the "best guess" of Congress and the state legislature.

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According to federal law, there are four groups of poor people who may be eligible for Medicaid services. The four groups all but defy simple description. One group, the "categorically needy", must be eligible for services. In general and for the purposes of this paper, the categorically needy consist of two groups: families with children and the aged, blind, and disabled. The other three groups, referred to as the "optionally categorically needy", medically needy, and "waiver" populations are made eligible if the states chooses options available in federal law. Each of these groups may include a different population and may be eligible for different Medicaid services.

As stated above, the Medicaid Act lists eleven mandatory services which must be provided by the state Medicaid program to all categorically needy recipients, and if included in the state plan, the optionally categorically needy. These mandatory services are considered to include basic medical care and include: inpatient hospital care, outpatient hospital care, laboratory and x-ray services, skilled nursing facility services for persons over age 21; family planning services and supplies to individuals of child bearing age; physicians services; nurse midwife services; home health services, including medical supplies and equipment; rural health clinic services; services to pregnant women; and, early, periodic screening, diagnosis and treatment services for persons less than 21. (42 U.S.C. Section 1396a(a)(10)(A))

In addition to these mandatory services, the Act lists numerous additional services which state may choose to include in the Medicaid program and list in the state plan. These optional services are: Podiatrists' Services, Optometrists' Services, Chiropractors' Services, Private Duty Nursing, Clinic Services, Dental Services, Physical Therapy, Occupational Therapy, Speech, Hearing and Language Therapy, Prescribed Drugs, Dentures, Prosthetics Devices, Eyeglasses, Diagnostic Services, Screening Services, Preventive Services, Rehabilitation Services, Services for Persons Age 65 or Older in Mental Institution, Intermediate Care Facility Services, Intermediate Care Facilities for MR/DD Persons, Inpatient Psychiatric Services for Persons Under Age 22, Christian Science Schools, Skilled Nursing Facilities for Persons Under Age 21, Emergency Hospital Services, Personal Care Services, Transportation Services, and Other Practitioners' Services (42 U.S.C. Section 1396d).

As mentioned earlier, the Medicaid Act requires that a certain set of core services be provided to eligible recipients. Of key importance to birth to 21 year old population is the provision of Early, Periodic Screening, Diagnosis and Treatment Services (EPSDT). EPSDT is not a service, per se, but rather a provision enabling children below the age of 21 to receive services from the state's Medicaid program. The key to EPSDT coverage is what services this population will be entitled to receive.

EPSDT requires states to provide a screening that includes a health and developmental history, a comprehensive physical examination, vision and hearing testing, laboratory tests, and dental screenings for children over 3 years of age. States must have periodicity schedules established that define the frequency of screening and provide for treatment of any problems identified during these screenings. In April, 1990, significant specificity was added to the requirements. The Omnibus Budget Reconciliation Act (OBRA 89) mandated states to have individual periodicity schedules that meet "reasonable standards of medical and dental practice". Additionally, states now must provide all "treatment" for which federal reimbursement is allowed without regard to that service being listed in the state plan. The significance of OBRA '89 provisions is enormous. In essence, no Medicaid-eligible person less than 21 years of age can be covered of any medically necessary service for which federal reimbursement is available.

Given the general overview of the Federal Medicaid provisions and the enabling statutory and regulatory language of the Individuals with Disabilities Education Act of 1997 (IDEA 97), the foundation for a collaborative working relationship between Medicaid and Special Education was set. Congress made it clear that nothing in the implementing regulations of the IDEA 97 (20 U.S.C. §1400 et seq.) is intended to relieve an insurer, Medicaid, or other third party from an otherwise valid obligation to provide or pay for services to a student with a disability. In addition, a non-educational public agency may not disqualify an eligible service for Medicaid reimbursement because that service is provided in a school context (34 CFR §300.142(b)(ii).

The Maine Experience:

The Department of Education and the Bureau of Medical Services (Maine's Medicaid Office) began its working relationship in the mid-1970's. Child Development Services, Maine's program responsible for the birth to five population under the Individuals with Disabilities Education Act, was the first program in the Department of Education to work directly with the state's Medicaid office. Through the combined efforts of dedicated personnel within both departments, parents and providers a model program of collaboration was forged. Maine became one of the first states to use the concept of pooled funding to maintain, enhance or expand programming opportunities for its youngest citizens.

In 1990, through the insightful leadership of the state Director of Special Education, a part time contracted position was created to explore ways that Medicaid reimbursements could be used to augment funding to local schools. Shortly after this consultant was hired, the governor's office hired an outside consulting firm to identify ways that programs across state government could collaborate to build a seamless systems of service delivery for Maine's children and youth.

As a result of this effort, the Administrative Case Management pilot was developed. The underlying concept of this initiative focused on the recoupment of the indirect costs of the service delivery system and the recognition that schools could play an important role in the successful implementation of the EPSDT program. School nurses, guidance counselors, social workers, personnel service staff and psychologists provided an array of services which could be covered under the EPSDT program. Examples of the types of services targeted were: outreach, health and mental health screenings, health and mental health education, follow-ups with parents of children with health and mental health problems, and maintenance of health records.

In addition to this ACM initiative, the possibility of creating a rehabilitation option for local school administrative units was also recorded. Due to the reduction in force mechanism that was underway in state government, no follow up work on this initiative was undertaken at this time.

Before any SAU would agree to participate, however, it was necessary for the Commissioner of Education to ensure that the units would not be penalized financially for participation. To ensure this, the commissioner signed a mutually agreed upon document that recognized any revenue received as a result of participating in this initiative would not be offset by a reduction in general purpose aid. In other words, the state promised a maintenance of effort to the participating units and that any revenues received would be viewed as augmentation funding not replacement funding.

Three school administrative units were recruited to be the initial participants in this initiative. These SAU's represented a large urban district with a high number of state ward/state agency clients, the largest rural SAU, and a small rural district with a very active school based health center component. In the second year of the pilot, the state-funded school for the deaf was recruited to be a pilot. These districts entered into contractual arrangements with the local provider of EPSDT services in their regions. This pilot proved to be very successful and remained in effect until 1995 when the Medicaid program went to a managed care system of service delivery and ultimately subcontracted the EPSDT services being provided by its agents to a private entity.

By 1995, however, Maine's fiscal problems continued to worsen and the state found itself in the midst of a fiscal crisis. State fiscal and personnel resources had been significantly reduced over the proceeding several years. In terms of educational funding, the state's share of educational funding to local schools had been reduced repeatedly of several years, thus placing a greater financial responsibility for the education of Maine children on the local taxpayers. Despite the success of the ACM pilots, SAU's access of Medicaid reimbursement for health related services provided as part of the Special Education program was minimal. A limited number of SAU's enrolled as providers of services for some direct, fee-for-service programs (i.e., occupational therapy, physical therapy, speech/language services, and day treatment services). Receipts from these services, however, were

negligible. Numerous perceived barriers to becoming Medicaid providers were cited by SAU's. Some of these barriers were: burdensome documentation requirements, physician referrals, qualification of providers, billing procedures, and threat of reduced general-purpose aid.

Realizing that something needed to be done, the governor's office instructed all departments within state government to examine all programs to ensure that these programs are being operated in the most economical and efficient manner possible. The governor entered into a contractual arrangement with another outside consulting firm and instructed the Departments of Human Services, Education, Mental Health, Mental Retardation and Substance Abuse Services and Corrections to work cooperatively with this consulting firm to pursue opportunities for increasing federal funding, both prospectively and retrospectively.

At the time, taxpayers were contributing about \$120 million toward the costs of special education. Through the use of an out of state consulting firm, it was estimated that approximately 40 to 50 million dollars could be qualified as health related expenses. It was determined that the State could use the Medicaid program to recover some of the costs for health related services provided by the Department of Education and the local schools. Efforts to assist the enrollment of local SAUs as Medicaid providers began. With the leadership of the Department of Education the majority of school administrative units within the state enrolled as providers in the voluntary program within a six-week period.

Costs identified included the health related portion of special education costs, such as occupational therapy, physical therapy, speech/language therapy, nursing services, vision services, hearing services, health screening, behavioral rehabilitation services, rehabilitative assistance and medical transportation. With the assistance of the this consulting firm, the State Departments of Human Services and Education worked collaboratively to establish a monthly blended payment system which reimburses SAUs for the full range of covered services included in the Individual Education Program (IEP).

In order to establish this blended rate, a rate setting study was conducted to determine the actual cost of providing each service and the historical utilization patterns for each service per disability category identified in the IDEA. The rate setting study examined the costs in 14 geographically diverse school units to determine the average cost of providing each service. One-thousand randomly selected special education students in these 14 schools were identified. The percentage of students within each disability group who use one or more of the covered services (utilization rate) was determined. Pursuant to repeated follow up with the regional office of the Health Care Financing Administration (HCFA), the blended rate was approved.

Concurrent with these conversations at the regional HCFA level, state personnel representing both Medicaid and the Office of Special Services began work on drafting policies to create the School Based Rehabilitation Services. Effective January 1, 1998, the School Based Rehabilitative Services program became a part of the Maine Medical Assistance Manual. Upon the adoption of the SBRS policy, SAU's began submitting retrospective and prospective claims. To date, the program has been judged to be a huge success. Highlights of the information gathered from local SAUs are included at the conclusion of this paper.

As part of the continuing implementation of the School Based Rehabilitation Services initiative, a small interagency work group has become institutionalized. This group is represented by policy and funding personnel from both the Office of Special Services and the Bureau of Medical Services. The purpose of this group is to act as a filter between the local schools and the respective Departments. Examples of the types of issues identified as potential "hot spots" by the field include: audit criteria, issues relating to "qualified provider" standards, release of information requirements, etc. Members of the work group use the information to determine collaborative training opportunities, identify areas of policy which may need revisions and/or further clarification, define specific target audiences for training, exchange information with licensing and credentialing bodies and to improve overall communication between the interest parties at the local schools and state agencies. It is the

general consensus of group members that this strategy is very beneficial in improving the overall quality of the program and the provision of services.

Medicaid reimbursements for various health-related services delivered within the public school settings should be viewed as supplemental funding not as replacement funding. School Administrative Units have been cautioned and advised against using anticipated Medicaid revenues in their local budget projections. There are no maintenance of efforts provisions tied to Medicaid reimbursements. In fact, school may experience large fluctuations year to year in the amount of reimbursements received from the state Medicaid office.

Medicaid as one of the largest payers of health related services for children birth through 21 has a defined place in Maine's public school. The long-standing collaboration between the Bureau of Medical Services and the Office of Special Services has resulted in a cadre of reimbursable services, which are delivered within local school administrative units. The ultimate goals of the interagency collaboration are to improve access to services for Medicaid-eligible children while simultaneously assisting the school administrative units' efforts to support the costs of special education for children with disabilities.

Highlights of Medicaid Survey of School Administrative Units January, 2000

Superintendents, business managers and Directors of Special Education in all two-hundred eighty-five school administrative units (SAU) received surveys. One hundred twenty six surveys representing individual SAUs were tallied and entered into the database. Ninety-seven percent of the school administrative units (SAU) that responded, reported billing Medicaid during FY 98-99. The majority (91%) indicated that they had billed for School Based Rehabilitation Services and 31% had billed for Day Treatment Services.

More than \$22 million has been reimbursed to SAU in Maine through the Medicaid/Department of Education collaborative. These revenues have been utilized by the SAUs in a variety of ways. Almost half (48%) stated that they used the Medicaid revenues to maintain or expand special education and/or health related programs; more than a quarter of the respondents (28%) used the money to purchase equipment or materials related to special education and/or health related programming; and, approximately 11% of the SAUs allocated monies to pay for licensure, other professional fees and/or continuing professional education. Eleven SAU had not made a determination regarding allocation of Medicaid resources at the time of the survey.

64% of the reporting SAUs indicated that the record keeping responsibilities required by SBRS was at least "what was expected" or "easier than expected".

The need for on-going training was also identified. Fifty-eight percent were interested in further training pertaining to Medicaid and its programs. Eighty-one percent of those school units requesting further training identified Medicaid Reimbursable Services and information on how to bill Medicaid independently (60%) were identified as training topics of interest. Eighty-seven percent requested that these trainings be conducted in a face-to-face format as opposed to Distance Learning (19%) or Train-the-Trainer (16%).

Of the 126 SAU responding, 48 stated that they had some unanswered questions regarding the Medicaid Program. In general their questions can be grouped into four major topics: audit process and requirements, how to deal with State Wards State Agency Clients, billing procedures, and longevity of the program.

When asked if there were any suggestions for improving the Medicaid initiative, 47 respondents replied with a range of answers. In general, there appears to be a need for some type of consistent, ongoing communication between DOE and the SAUs, need for more informational meetings and trainings, a smoother audit process and improved working relations between Medicaid, the Department of Education and the independent billing service most SAUs have retained under contract.